Journal

OF THE NATIONAL ASSOCIATION OF CHIROPODISTS

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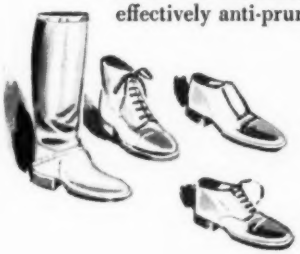

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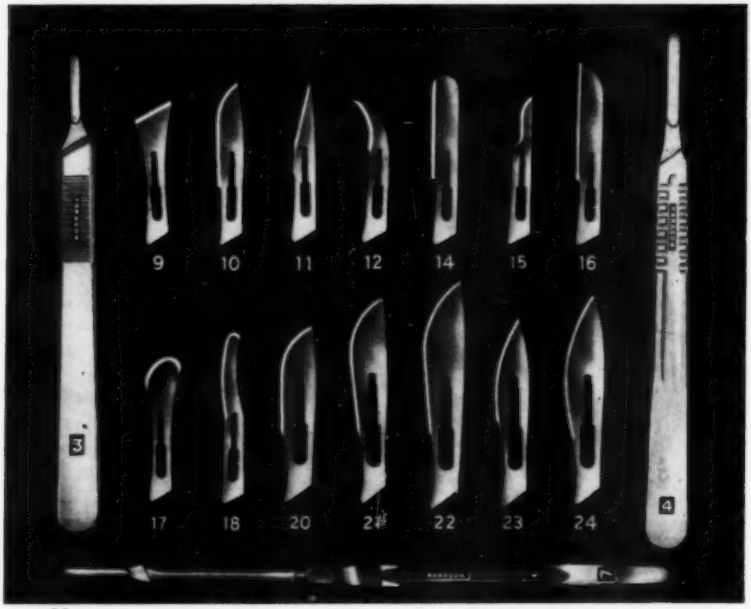

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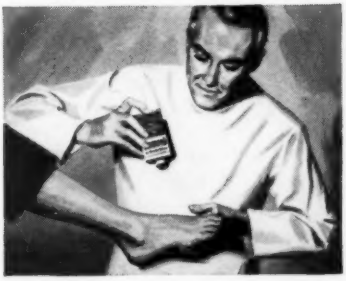

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VOLUME 45 SEPTEMBER, 1955 NUMBER 9

SESAMOID SURGERY OF THE GREAT TOE

Thomas R. Amberry, D.S.C., A.C.F.S.*
Long Beach, Calif.

OSSA SESAMOIDEA, the sesamoid bone, is so named from the Latin because of its resemblance to a grain of sesame.

Under the head of the first metatarsal bone are found constantly two sesamoid bones, each of which is enclosed in one of the tendons of the Flexor Hallucis Brevis, and termed respectively the medial and lateral or tibial and fibular sesamoid. They have a smooth cartilaginous surface upon which the head of the metatarsal bone rests and glides. The functions are to modify pressure, to diminish friction, and furnish a fulcrum for the Flexor Hallucis Brevis, which assists in holding down the base of the proximal phalanx of the great toe and keeps it close to the head of the metatarsal bone when the foot is bent on the toe in locomotion. Incidentally, they are a protection to the tendon of the Flexor Hallucis Longus which runs forward to its insertion in the toe in a groove between them. That they are not developed in response to physical requirements of the adult is evidenced by the fact that they are present as cartilaginous nodules in the fetus. They must be regarded then, according to Thilenius, as integral parts of the skeleton phylogenetically inherited. Physical and physiological factors come into play in selecting and in regulating the degree of development of the original cartilaginous nodules.

The medial sesamoid is larger than the lateral. Ossification centers for these sesamoids ordinarily appear about the ages of seven years in girls and ten in boys. Once ossification begins, it proceeds rapidly and is usually complete at the end of a year or at the most, two years. There may be one or several ossification centers for each sesamoid bone. These divisions may be equal or one fragment may be larger than the others. At times the sesamoid may be tripartite, or there may even be multiple segments. Often they are so large that one is in doubt as to whether they are merely large bones or enlarged pathologically. This is especially true when they are rather irregular in shape and not smooth-oval as in the

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majority of cases. In very heavy people and in persons who have to walk and stand a great deal and in those that have to carry heavy burdens, they are usually very large. In lightweight people and in persons who are not a great deal on their feet, they are usually small. Apparently the size of these bones, like others of the skeleton proper, are governed by physiologic laws.

Fractures of the sesamoids are very common and are usually due to direct violence such as jumping, stepping off stairs with the toes in extreme hyperextension, falling from a height, hitting the foot against a rock or pavement, dancing and skating accidents, athletic activities, or the impact of a heavy object on the foot. It is generally believed that the divided type of sesamoid bone is more likely to suffer from a blow striking the sesamoid beneath the head of the first metatarsal bone. Injury can also occur as the result of sudden, forceful hyperextension of the great toe.

The symptoms of a fracture are sudden sharp pain at the time of the injury, or at a later date, pain following the appearance of secondary changes. The pain is situated over the affected sesamoid, and is aggravated by movement of the metatarsophalangeal joint of the great toe.

Pathological conditions to which are ascribed the pain, are inflammatory changes of bursae in relation with the sesamoid, arthritis, and subluxation of the whole or part of the bone. Pain tends to diminish with rest, but returns on exercise, so that the patient is often forced to walk on the lateral side of the foot. Tenderness can be elicited by direct pressure on the plantar surface of the damaged sesamoid.

The indirect type of fracture is produced only when the trauma causes a sudden hyperextension of the toe followed by a tightening up of the adjacent tendinous structures. The infrequency of the injury of the fibular sesamoid of the hallux is attributed by Bizarro to the ease with which this sesamoid escapes into the space between the metatarsal heads following abduction of the toe.

The displacement of the lateral sesamoid into the interosseous space produces, in addition, a rotatory deformity, in which the nail of the toe comes to look inwards. This latter change, although but rarely mentioned, is quite characteristic of these cases, and it serves to emphasize the atavistic influence.

The diagnosis of a fractured sesamoid should be made guardedly owing to the frequency of the multipartite state. The recognition of these normal divisions is significant from the medico-legal aspect, inasmuch as they have frequently been mistaken for fractures. When multipartite, the gap between the separated portions is even, the long margins smooth, rounded, and well calcified, whereas fractured edges are indented, irregular and porotic. Congenital subdivisions are usually transverse, and rarely oblique or longitudinal. The degree of separation is also said to be wider in fractures than in congenital separations. Indistinct stippling may occur in a sesamoid, and may be due to osteochondropathy or sesamoiditis. Of aid in diagnosis in fractures is the sudden onset of symptoms, immediately following trauma. A diagnosis of "old fracture" would depend on the presence of callus; otherwise, histologic examination after the removal of the sesamoid bone would be necessary for convincing proof. Other proof would be to have a roentgenogram taken before the injury, and another after the injury.

In a sesamoidectomy performed for the removal of the affected sesamoid bone, or bones, great care must be taken in removing the bones from their tendons lest the tendons be severed. Both sesamoids need not and should not be removed unless there is a clear indication to do so, since the excision of both increases the risk of dividing the tendon Flexor Hallucis Brevis and will result in a hammer toe deformity.

Authorities such as Campbell, Dickson and Diveley, Gottlieb, Mercer, Inge, Speed, Ferguson and Smith have all reported on the successful removal of the sesamoid bones, but none reported the contraindications to removal. It has been reported to the writer that in some cases following removal of one sesamoid, it may be necessary at a later date to remove the other sesamoid to maintain functional stability. With the previous statement in mind, the opinion is expressed that whenever the condition warrants, surgical intervention is the treatment of choice rather than prolonged pallative treatment. Removal of the sesamoids not only overcomes the discomfort due to their displacement but it prevents the impingement of the lateral sesamoid upon the structures in the first inter-metatarsal space. Perhaps of greater importance, it constitutes in effect a tenotomy of the short muscles attached to the base of the phalanx, especially of the adductors, and so overcomes their deforming pull upon the toe. It has a definite corrective effect on the valgus deformity.

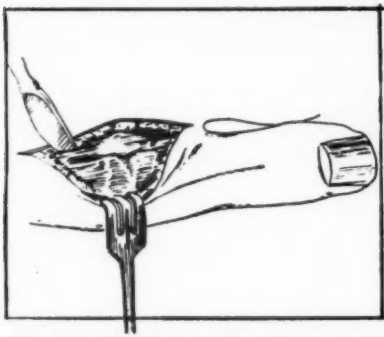

Fig. 1.—Incision on the dorsum of the foot along the lateral border of the Extensor Hallucis Longus. Sharp dissection down the lateral sesamoid bone in its bed in the adductor and Flexor Hallucis Brevis tendons.

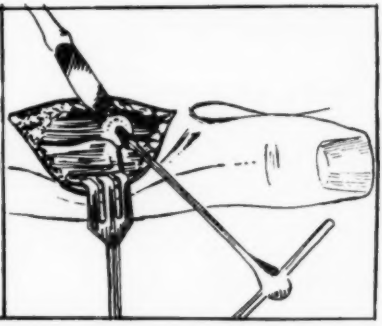

Fig. 2.—With sharp dissection, the lateral sesamoid is exposed. Note the special sesamoid screw to enable the assistant to maintain a firm grip on the bone. The bone is drawn upwards and dorsally and freed from its bed.

A Surgical Procedure for a Lateral or Fibular Sesamoidectomy

The incision is begun just proximal to the interphalangeal joint of the great toe and extended along the lateral border of the Extensor Hallucis Longus tendon to a point 2.5 cm. proximal to the metatarsophalangeal joint. This incision facilitates removal of the sesamoid and obviates the trauma to the skin and soft structures. (Fig. 1.) The dissection is carried deep on the lateral side of the joint; the Adductor Hallucis tendon is isolated at its insertion to the base of the first phalanx. The lateral sesamoid bone is next dissected out of its bed in the Adductor and

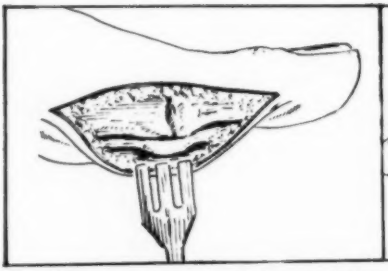

Fig. 3.—For removal of the medial sesamoid, a curved incision, its convexity toward the plantar aspect of the foot, is made along the medial aspect of the metatarsophalangeal joint. The flap is retracted.

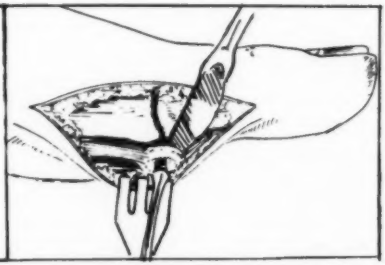

Fig. 4.—The Flexor Hallucis Brevis is brought into view. With the special sesamoid screw the sesamoid is carefully dissected free, with sharp dissection, and the bone is enucleated.

Flexor Hallucis Brevis tendons. Its removal is tedious and care should be taken not to damage the Flexor Hallucis Longus tendon. The sesamoid is freed at its distal and proximal edges with a sharp scalpel. Scissors should not be used to clip the soft structures. It is then grasped with a towel clip, small hook, or insertion of a special "sesamoid screw" into the sesamoid is often of great help in this respect. (Fig. 2.) The bone is then drawn upwards and dorsally as dissection is made medially beneath it and frees it from its surroundings, care being taken to avoid any damage to the tendon which lies buried between the bones. The removal of the lateral sesamoid in the course of any hallux valgus operation should be performed whenever this bone has been tender and painful on walking, or laterally displaced. If the fragile soft tissue in this region should be damaged, repair should be done with "figure-of-eight" sutures of 20 to 40 day catgut to bring the subcutaneous structures into apposition. The skin is closed with dermal.

Surgical removal of the medial or tibial sesamoid is carried out with a curved incision, its convexity toward the plantar aspect of the foot, made along the medial aspect of the metatarsophalangeal joint. The flap is retracted and with sharp dissection the Flexor Hallucis Brevis is brought into view. (Fig. 3.) The sesamoid is grasped with the special sesamoid screw to enable the assistant to maintain a firm grip on the bone, and then with sharp dissection keeping the knife close to the bone (Fig. 4.), the tendinous attachment to the sesamoid is carefully dissected free and the sesamoid is enucleated. Deep sutures of choice may be used if needed. The skin incision is brought in apposition with dermal interrupted sutures.

Post operative treatment in cases of this nature is important. After the wound has been closed, a sterile compression dressing is applied. The toe should then be splinted. The splint can be incorporated into the bandage. The foot should be elevated and placed under a cradle with ice packs to the area for the first twelve hours to keep painful edema to a minimum. During this time of elevation, the foot should be dorsiflexed on the leg and the lower leg flexed on the thigh several times a day. This prevents stasis and aids in the prevention of phlebothrombosis and

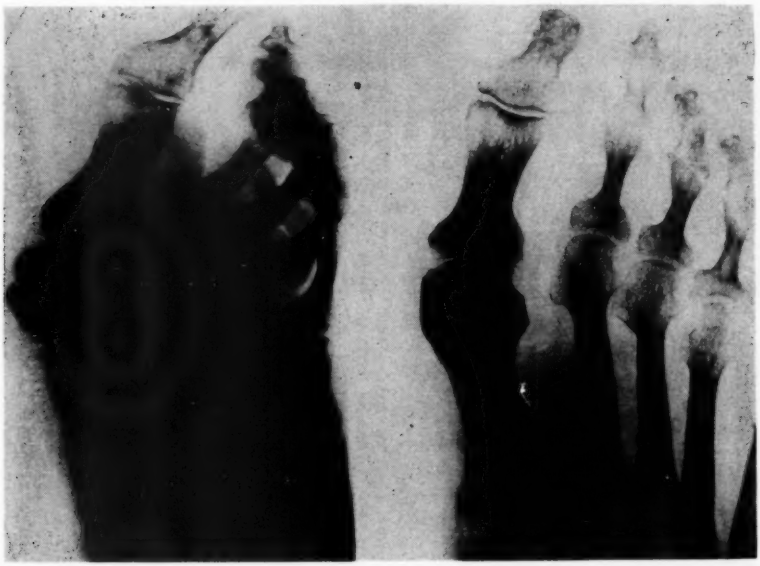

Fig. 5.—Anterio-Posterior reveals a bipartate sesamoid. Lateral view shows hypertrophy and segmentation. Patient's chief complaint was pain in the M. P. joint. Palliative and orthopaedic measures were of no benefit. Surgery of the sesamoid left the patient with a pain-free joint.

thrombophlebitis. A routine inspection of the extremity for edema and disparity in the circumference in the leg. This can be noted by using strips of paper, rather than a tape measure, and palpation of the gastrocnemius and dorsiflexion of the foot to elicit a Homan's sign. If signs of infection are present, immediate administration of an antibiotic should be instituted. Penicillin G with procaine, 300,000 units intermuscularly per day, is the author's drug of choice. The patient is to remain off his feet the first twenty-four hours, and after seventy-two hours, the patient is permitted ambulation but must carry the burden of the weight on the lateral border of the foot. The first redressing of the wound is four or five days following the operation, providing there is no infection. The sutures are removed about the tenth day, at which time the patient is allowed to wear a cut-out shoe to accommodate the wound and weight-bearing is resumed on the entire foot at this time. On the fourteenth day, hydrotherapy is instituted. The patient is fitted with an orthopaedic appliance and a correct shoe.

For those who prefer that the foot be immobilized the entire time that the sutures are in, the following may prove favorable. A plaster cast constructed along the lines of a slipper is applied to the foot, holding the toe in a slight flexion and abduction. At the end of ten days, the cast is bivalved, straps and buckles are applied and the cast can be used as a protective night splint. At this time the sutures are removed to facilitate passive and active exercise of the toe.

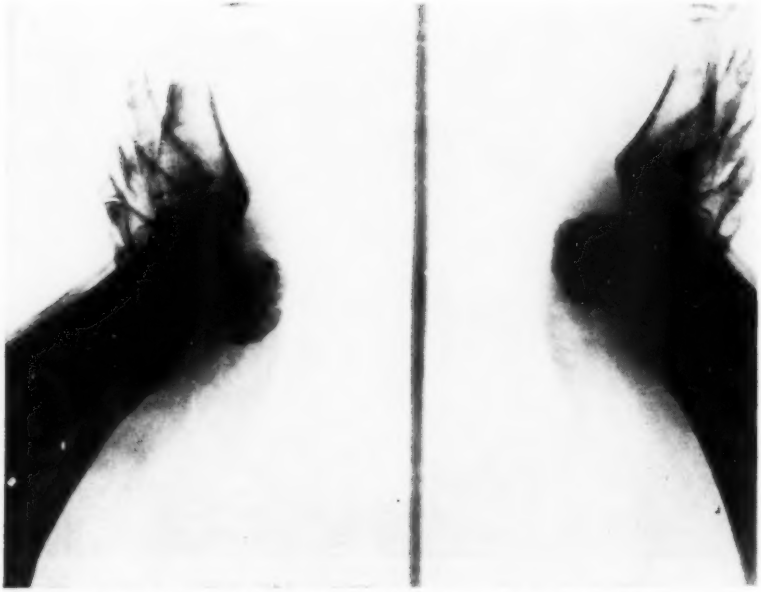

Fig. 6.—Lateral views of the first M. P. joint reveal a multipartite sesamoid, associated with hypertrophy. Physical examination of the foot reveals a painful verruca that had been treated for over a year. Surgical intervention with removal of the sesamoid brought about the disappearance of the verruca and left the patient with a pain-free foot.

Summary: Surgery of the sesamoids has too often been overlooked as the method to correct painful conditions of the great toe. Gratifying results have been obtained for patients with a verruca or a deep-seated nucleus situated under the sesamoids, or where the sesamoids have been fractured, and secondary changes have taken place leaving the patient with a painful foot. Surgical intervention is the treatment of choice. Figures 5 and 6 are illustrative cases.

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AN EVALUATION OF RESULTS OBTAINED THROUGH SURGICAL AND NON-SURGICAL THERAPY IN HALLUX VALGUS AND HALLUX RIGIDUS

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CONSERVATIVE treatment or surgery. Which shall it be? A short time ago the writer interviewed several prominent orthopedic surgeons and practically every one had what they considered their own variation of the numerous techniques for hallux valgus surgery.

As Dr. E. I. Lloyd states, "Surgeons are still divided on which operation is best and are inclined to put forward their own personal impressions unendorsed by the patient. The patient's view of success of an operation may differ widely from the surgeon." For example, it is possible to have an excellent cosmetic result in a stiff, useless, and painful toe. So that the patient's view of the functional result frequently differs widely from that of the surgeon.

The surgeons interviewed were uncertain as to the end results because in most cases they were unable to follow the cases for a long period after surgery was done. Texts that were consulted merely reported techniques for the surgery, intimating that all were successful. This was not quite enough proof that surgery was the answer, so the literature was consulted for reports by surgeons who had done the work and were able to report on the results after seeing the same cases many years later.

I. Hallux Valgus

These studies showed some interesting etiological aspects. It appears as though faulty footwear has been exaggerated as the cause of hallux valgus. While it is true that improper footwear plays a contributing role in the formation of this defect, it also develops in primitive populations who have never worn shoes. The etiology appears to lie in the weakness or defect in the architecture of the foot, such as metatarsus primus varus, hypermobile of the first metatarsal segment, or foot imbalance creating improper distribution of weight stresses on the forefoot.

The strong hereditary influence is demonstrated by an early onset of symptoms in a large group giving a family history of hallux valgus.

A multitude of operations for hallux valgus have been described.

These operations have been named after their originators. These are: Keller, Schanz, Mayo, Hueter, Lapidus, McBride, Schede, Porter, Silver, Trustlow, Peabody and Erlacher; plus many more, too numerous to mention.

Most all of the techniques for hallux valgus surgery fall into one of three categories:

TYPE I. Surgery which aims merely to remove the enlargement on the medial side of the great toe joint.

TYPE II. Surgery which removes the enlargement of bone as above and in addition corrects the lateral deviation of the great toe.

A. Keller or Schanz operation is most frequently used. The base of the phalanx is resected. At least one quarter and sometimes one half inch of the base is removed.

B. Mayo or Hueter operation in which the first metatarsal head is resected by a straight osteotomy, the line being carried proximal to the exostosis.

TYPE III. A combination of the above in which there is the removal of the enlargement on the inner side of the great toe, the lateral deviation of the great toe is corrected and an attempt is made to correct any metatarsus primus varus which may be present.

A. Lapidus operation which aims to fix the first metatarsal in correct relationship with the second metatarsal. A bony fusion is produced between the first metatarsal and cuneiform bones and the adjacent surfaces of the first and second metatarsals.

B. McBride operation which corrects metatarsus varus by using muscle action to correct medial angulation of the first metatarsal. The conjoined tendon (flexor hallucis brevis and the transverse and oblique heads of the adductor hallucis) are dissected from their attachment to the base of the phalanx and reattached into the dorsum of the head of the first metatarsal. The McBride operation is used in the adolescent or flexible type, while the Lapidus operation is used in the more rigid type of foot in adults.

Bonney and Macnab report the study of an unselected group of patients who underwent operative treatment for hallux valgus at the Royal National Orthopedic Hospital, London and Stanmore, between the years of 1920 and 1950. The examination of cases involved answers from the patient and from clinical notes of details of the preoperative condition, operative methods, postoperative treatment and course, and eventual result. Clinical observations were rigid enough to exclude personal prejudice.

In one series of 266 operations for hallux valgus, 188 were of the Keller and 78 were of the Mayo type.

The follow-up period after surgery was, in many cases, for a number of years. Seventy-three cases were seen less than one year after surgery; 30 cases were seen one to five years after surgery; 30 cases were seen six to ten years after surgery, and 27 cases were seen over eleven years after surgery.

Evaluating the anatomical results which showed the degree of angulation after surgery, it was found that approximately 100 cases ended up with hallux valgus less than 20 degrees; 96 cases ended up with hallux valgus from 20 to 30 degrees; 66 cases ended up with hallux valgus from 30 to 50 degrees, and four cases ended up with hallux valgus over 50 degrees.

Evaluating the subjective functional result, showing what symptoms patients had after surgery, approximately 120 cases complained of symptoms only occasionally causing no restriction of normal activity; 78 cases had constant symptoms causing intermittent limitation of normal activty; 65 cases had no symptoms and three cases had constant symptoms causing total limitation of normal activity.

Evaluating the objective functional result as regards range of motion, approximately 100 cases had marked limitation of either dorsiflexion or plantar flexion; 90 cases had dorsiflexion 30 degrees or more; active plantar flexion, 15 degrees or more; 66 cases had marked limitation of both dorsiflexion and plantar flexion and in 10 cases, there was no movement possible.

Using a different operation, the metatarsal osteotomy which corrects the metatarsus primus varus and leaves the first metatarsophalangeal joint untouched, 39 operations were done on 26 adult cases. The surgeons admit that the anatomical and functional results have not been good. Actually, only two cases had a perfect result. Out of 26 patients, six were found to require either the fitting of surgical shoes, or further operation to allow them to wear ordinary shoes.

In the adolescent group, surgery has been directed to the correction of the effects of the metatarsus primus varus. The results of the Keller operations performed in the presence of a growing epiphysis have been uniformly bad. The operations have been variants of the basic type of metatarsal osteotomy and the results have been very poor.

In a survey of 54 feet, in 34 patients ranging in ages from 10 to 17 years of age, surgery directed at the correction of the metatarsus primus varus using metatarsal osteotomy showed a high percentage of failures. In 34 of the 54 feet operated upon, the metatarsus varus returned to the original state or to a larger angle than before operation, after intervals varying between one day and three months after operation. Only 12 cases were considered to have a good result requiring no further surgery.

As to the interval of follow-up of these cases, 11 patients were seen under one year after surgery; 17 patients were seen one to five years after surgery and 6 patients were seen more than six years after surgery.

In another group of patients, results were recorded after excision of the exostosis alone. Ninety-seven operations were done on 68 patients. The anatomical results were poor but the subjective functional results were good. However, of the 68 patients, 25 were found to require further conservative or operative treatment. This suggests that the apparently good functional results are possible only by additional treatment. From this report, it appears that trimming of the exostosis alone is justified only (1) when the bunion itself is the sole cause of symptoms and the fixation of the first metatarsophalangeal point prevents further deviation of the great toe (2) when general conditions (such as polyarthritis) or local conditions (such as an amputated second toe), and removal of a large exostosis is necessary for the fitting of surgical shoes (3) when the exostosis is the sole cause of symptoms and a cosmetically good result is not required.

The causes of partial failure may be grouped under three headings:

1. Preoperative factors.

The age of the patients determines the eventual results. The younger group had the better results.

2. The type of hallux valgus.

(a) the adolescent type in which painful symptoms occur in adult life as an extension of deformity and occasional pain starting in childhood.

(b) the adult type in which pain and deformity first appear in adult life.

(c) the arthritic type in which pain and deformity are a part of local or generalized degenerative joint changes. The results of the third group were worse than those in the first two.

3. Occupation.

Best results were obtained in cases engaged in sedentary occupations or in those who were able to modify their activity when pain became severe. In cases that involved long continued strain on the feet, adoption of less active work was necessary.

A survey in 1947 of the end results of operations for hallux valgus in 55 operations on 33 patients at the Massachusetts General Hospital, showed that the Keller operation was hardly successful. The Keller procedure was used in 66 per cent of the cases.

Conclusions from this study:

1. The Keller operation does not restore that degree of strength of the great toe which is essential to normal locomotion. The reconstructed push off mechanism either appeared weaker after operation than before or was unchanged in 89 per cent of the cases. This condition was due to weakness of the flexor mechanism of the great toe. The tendency to splayfoot was either unchanged or was increased by the Keller operations.

2. Calluses beneath the heads of the metatarsals usually became more prominent following operation.

3. It does not effect a significant correction of the mechanical faults that usually coexist in the foot as a whole. Ninety-one per cent of those operated upon failed to show improvement in structure of the foot as a whole; 67 per cent continued to wear arch supports.

4. It throws upon the rest of the foot a burden as great or even greater than that imposed by the deformity for which the operation has been performed. Its value is limited and is in a large measure only local.

5. Inquiry regarding return to employment disclosed that 90 per cent of the patients were employed in sedentary occupations which permitted periods of sitting.

6. Varus of the first metatarsal was unchanged in 90 per cent of the cases and in 9 per cent it had increased.

Two hundred operative results on 108 patients with hallux valgus were reviewed in another series. The surgery was done by 25 surgeons at the New York Orthopedic Hospital. The length of time which elapsed between operation and final evalution was about twenty-eight months.

They reported satisfactory results, but in a later report (1950), they reported that although the procedure relieved the pain of the inflamed bursa, the underlying hallux valgus was not improved. They explain by saying that changes in surgical techniques are bound to occur as experience accumulated and there should be no reluctance to admit a change of ideas with the passage of time.

The original surgery was a Mayo. In the last report, they report success with the Keller in 193 operations. They specify, however, an extended convalescence. Hospitalization for from fifteen to eighteen days. Patient is non-ambulatory for fourteen days and unable to wear regular shoes for one month. Patients with standing jobs were unable to carry on

their duties until six to eight weeks had elapsed. In many cases, discomfort persisted as long as six months after surgery, when patient was able to indulge in unlimited activity.

The respective merits of the two principal operations for hallux valgus has been argued for years. Whether it is best to exercise the head (Mayo) or base (Keller) of the phalanx, together with the metatarsal exostosis.

Lloyd operated on 20 patients suffering from bilateral hallux valgus and did different operations on either side.

From one to three years elapsed after the operations and the patients were then asked to choose between the two toes, purely from the point of comfort.

The results of pain and comfort or discomfort were about the same for both operations. Fifty-five per cent found no difference, 20 per cent preferred metatarsal head removal and 25 per cent preferred base of phalanx removal.

In 1942 hallux valgus surgery was performed on troops in training at Fort Jackson.

This was a very significant report because vanity and the cosmetic reason for the operation did not exist. The soldier seeks surgical relief solely for pain.

Twenty-five soldiers were operated on and the results were followed in 88 per cent of the cases.

The surgeons conclude that the operative treatment for hallux valgus among training men restores too few to duty to justify its recommendation.

Even though there is a difference of opinion among surgeons as to what operation is more successful, most agree that it should never be done with the hope of eliminating other foot symptoms.

Perkins, who operated on 50 cases (Mayo), states that it does not relieve metatarsalgia—in fact, it makes it worse.

Lloyd, who reports a series of 20 cases, states that metatarsalgia existing before operation is not relieved by operation on a coexisting hallux valgus—even when the hallux valgus was the original cause of the metatarsalgia.

Rogers and Joplin, who report 55 operations, say that the changes which occur throughout the foot in company with hallux valgus, especially in the metatarsal and phalangeal regions, result in significant pain or discomfort and loss of function. These alterations are not relieved by the Keller operation. The Keller operation falls short physiologically as it does not restore structure and does not include correction of the associated functional and structural weakness of the foot.

Bonney and Macnab, reporting 518 cases, state that it does not appear as though Mayo or Keller surgery produces or aggravates metatarsalgia.

Cleveland and Winant, who report 193 operations, assert that hallux valgus is frequently accompanied by other painful foot conditions and one should not expect operation of the great toe joint to remedy coexisting foot complaints. Patients with painful callous or metatarsalgia or plantar neuroma should be advised that surgical correction of the hallux valgus per se will not relieve these symptoms.

Conclusion

1. Many operations performed for the relief of hallux valgus are

unsatisfactory because they fail to correct the deformity completely or leave a stiff joint or both.

2. The enormous wealth and great diversity of the operative procedures devised for the correction of the hallux valgus deformity is eloquent proof that this problem is far from being adequately solved.

3. In analyzing the various operations, it is found that each of them is concerned with and aims to correct some special part of the pathological anatomy of hallux valgus and bunions, but either leaves some portion of the deformity, or results in a defect that interferes with the perfect function of the foot.

4. All operations fall short of ideal.

5. Multiplicity of techniques gives an indication of their probable shortcomings and of the difficulty in the assessment of results.

6. If surgery must be resorted to, Keller's operation seems to be more successful. In the Keller operation, a certain optimal point is reached between the advantage of a large bone removal in the production of a wide arthroplasty and its only disadvantage is the production of a short great toe possessed of no active movement. In Mayo's operation, too small an excision results in a stiff joint, while too great an excision leads to an excessive transference of weight to the second metatarsal head. It is this rather critical level of bone removal which may account for the bad results of Mayo's operation in less experienced hands and the consequent disfavor into which this operation has fallen.

7. The uncertain and unsatisfactory results of hallux valgus surgery reserve it only as a last resort after orthodigita with traction, slings, splints, manipulation, latex shielding and mechanical padding have failed completely.

II. Hallux Rigidus

HALLUX RIGIDUS has been attributed to acute injury, prolonged trauma and strain of the great toe joint, the result of faulty weight bearing. It may also occur as a manifestation of a general polyarthritis. In the series of cases presented below, a positive family history predisposed to an earlier onset of symptoms; 50% of patients with an onset of symptoms before the age of twenty had a positive family history, whereas only 10% of the patients whose symptoms came on after that age knew of a similar condition in their relatives.

Lambrinudi is of the opinion that hallux rigidus occurs in those feet in which the first metatarsal head is on a higher plane than the other four and does not bear weight. This position is called metatarsus primus elevatus. This may also explain the common association of hallux rigidus and the valgus foot, since it is only by putting the foot in valgus that the first metatarsal can bear weights. He has shown that metatarsus primus elevatus is often demonstrable well before the degenerative joint changes are appreciable and that correction of this condition in the adolescent was followed by a regression of the changes in the first metatarsophalangeal joint.

Jack found "hyperextension" of the first metatarsal segment to be clinically demonstrable in 14 to 22 affected feet and he related the degenerative changes in the first metatarsophalangeal joint to this abnormality. In a series it was shown that a similar proportion (two-thirds) of the affected feet showed a metatarsus primus elevatus, but this de-

formity appeared to be in the nature of a fixed deformity rather than of a hypermobility as postulated by Jack in his development of Morton's views.

Whatever may be its role in etiology, metatarsus primus elevatus is clearly of bad significance in the prognosis of operating for hallux rigidus.

As to the relative length of the first and second metatarsals, it was found in one series that most patients with hallux rigidus had a first metatarsal longer than the second.

Surgery for hallux rigidus has been disappointing. In a series, 43 adult patients were operated on by arthroplasty of the Keller or Mayo type in 47 feet. Excision of the exostosis alone was done in 9 cases.

The length of follow-up of 25 cases was less than one year after surgery. Eleven cases were seen one to five years after surgery, 2 cases were seen six to ten years after surgery and 6 cases were seen over eleven years after surgery.

As to the age at operation, 2 cases ranged from ten to twenty years; 6 cases ranged from twenty-one to thirty years; 8 cases from thirty-one to forty years; 15 cases from forty-one to fifty years, and 13 cases over fifty-one years.

Evaluating the subjective functional result showing what symptoms patients had after surgery, approximately 21 cases had occasional symptoms causing no restriction of normal activity; 15 cases had constant symptoms causing intermittent limitation of normal activity, and 12 cases had no symptoms and no restriction of normal activity.

Evaluating the objective functional result as regards range of motion, 20 cases had marked limitation of both dorsiflexion and plantar flexion; 14 cases had no movement possible at the first metatarsophalangeal joint; 10 cases had marked limitation of either dorsiflexion or plantar flexion, and 4 cases had dorsiflexion, 30 degrees or more; active plantar flexion, 15 degrees or more.

In the only adolescent patient (a girl of twelve years) subjected to arthroplasty, the surgeons state that the result was extremely bad, and this unhappy impression has been amply confirmed by similar cases seen subsequently outside the present series.

The results of excision of the bony outgrowth alone were as poor as those of arthroplasty.

In another series, the surgeons state that the results in five patients upon whom six operations were carried out, must be considered as failures because of persistent pain, either alone or in combination with stiffness of the joint which had been operated upon.

On the other hand, chiropodists have reported good results using traction in hallux rigidus. Budin, Nemiroff, A. Jacobson and the writer have demonstrated its usefulness.

In one of the writer's cases, the joint space was increased one millimeter and full motion was restored using traction.

The patient was a white female, 36 years of age. Approximately one month before she presented herself, she sustained an injury to her back as a result of falling down some seven steps. She did not pay much attention to her foot at that time, but about one month after injury reported to the writer's office. This fall probably brought on symptoms and stiffness to an already traumatized joint.

Examination revealed a painful hallux rigidus of the right foot with

limitation of motion in all directions, particularly dorsally. Severe pain on weight-bearing.

Fig. 1.—Shows narrowing of joint space and osteophytic processes on the head of the first metatarsal and the base of the proximal phalanx. APRIL 23.

X-ray on April 23, 1951 (Fig. 1) showed a typical picture with osteophytes and marginal lipping of the involved joint. On the dorso-plantar view, the first metatarsophalangeal joint reveals osteophytic processes on the fibular side of the head of the metatarsal and the base of the proximal phalanx. Osteal accretions are noted on the tibial side of the same joint. The joint space is somewhat narrowed and the sesamoids are in good position although they are irregular in shape. There is a moderate degree of adduction of the first digit. The oblique view accentuates the irregularity of the external sesamoid bone and brings into view an osteophytic process of the tibial aspect of the base of the proximal phalanx. This process appears to be osteophytic in nature.

The opposite foot (left) was negative for any joint changes. The treatment given was traction (Ortho-trac) and after several treatments, the motion of the joint was gradually increased and pain was decreased.

Subsequent x-rays taken about six months later (October 31, 1951) (Fig. 2) showed an over-all increase in one millimeter of space. Normally, it is difficult to accurately ascertain such a small change because of positioning factors. However, using the second metatarsophalangeal joint as a control, the claim for the increase is valid. In both instances the joint space of the second metatarsophalangeal measure identically. This signifies that the dorso-plantar views on both dates are essentially the same. If this is so, then one can assume that the difference in the

measurements of the first metatarsophalangeal joint is fairly accurate, and is the result being promulgated.

In another of the writer's cases of hallux rigidus, traction therapy eliminated all pain, motion was restored, and the patient was able to wear practically any shoe. This was a 23-year-old white female who presented a painful, rigid, first metatarsophalangeal joint of the left foot. Onset of symptoms was about ten years ago, during which time there had been acute exacerbations and remissions. Pain and swelling was acute enough to cause her to limp at certain times. Diagnosis in the past ran from gout to acute arthritis and milk had been eliminated from her diet as it was thought that deposition of calcium was a factor. Strangely enough, no x-rays were taken during the entire time that symptoms were present.

Examination revealed a rigid first metatarsophalangeal articulation. There was no motion possible in either flexion or extension, actively or passively. No pain on pressure, but severe pain on weight-bearing, particularly in walking.

Examination of patient's shoe, which was about six months old, showed that the patient was favoring the first metatarsophalangeal joint by throwing the weight on the outside of the foot. The area under the first metatarsophalangeal articulation was not worn in the least, while the area in the lesser metatarsophalangeal joints was worn thin.

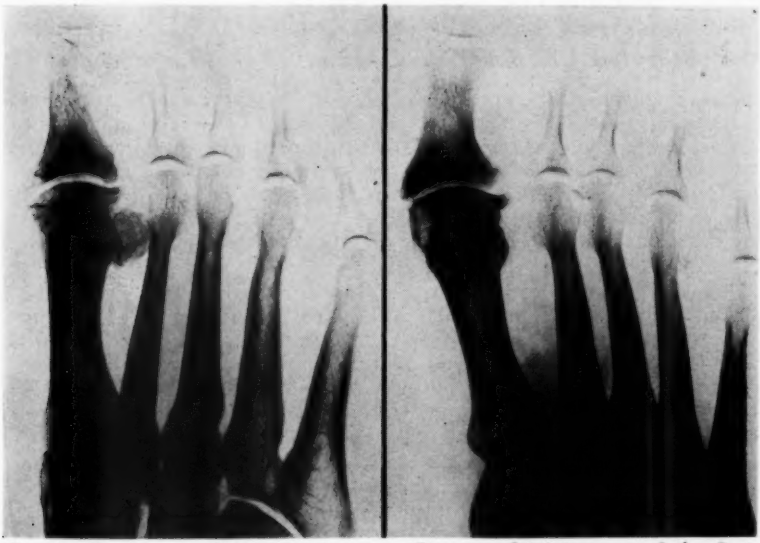

Fig. 2—Shows over-all increase in one millimeter of joint space of the first metatarsophalangeal articulation. OCT. 31.

This was confirmed by x-ray studies (Fig. 3), There was a thinning of the shafts of the second and third metatarsals and a broadening of the shafts of the fourth and fifth metatarsals. Other findings were a periosteal reaction at the outer side of the base of the first proximal phalanx

(Continued on Page 41)

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SUPPLEMENTARY REPORT — 43RD ANNUAL CONVENTION AND 36TH HOUSE OF DELEGATES

THE MAJOR accomplishment of this House of Delegates was the adoption of revisions to the Constitution and Bylaws. These eliminated the Council and Executive Committee and substituted an Executive Council, which consists of the elected officers who formerly comprised the Executive Committee with the addition of six councilors at large. No two of these executive councilors may be from the same state. The House of Delegates very wisely elected executive councilors who represented all areas of the country.

The various committees are grouped into councils, which are arranged in administrative divisions. Each administrative division is headed by a vice-president or the president-elect. The change also provided for two administrative officers in the national headquarters. These officers are (1) secretary and editor, (2) business administrator. This scheme will provide an effective working team. It has potentiality for great achievement for the association and the profession.

The other major change in the constitution and bylaws increased the size of the Council on Education and provides for inclusion of representatives from the chiropody colleges and from the Federation of State Boards.

Honorary Membership was conferred upon Wilfred E. Belleau of Milwaukee, Wis., and Vice Admiral Ross T. McIntire, now Executive Director of the International College of Surgeons.

Action of the House of Delegates provided Life Membership for the following members: Dr. R. E. Conway, York, Pa.; Dr. Victoria Dobrient, Milwaukee, Wis.; Dr. J. M. Roder, Milwaukee, Wis.; Dr. P. Hager, Milwaukee, Wis.; Dr. J. A. Becker, Olean, N. Y.; Dr. A. M. Hall, Philadelphia, Pa.; Dr. K. E. Fuller, Detroit, Mich.

Action was taken to direct the President, with the advice and consent of the Executive Council, to appoint a committee to consider ways and means for the establishment of a National Library in the headquarters building commemorating Dr. William J. Stickel.

The Conference on Nomenclature provided with some funds for operation. This Conference is working with the Committee of the A.M.A. on "Standard Nomenclature of Diseases and Operation."

A resolution was adopted that the N.A.C. Awards for Research be renamed "The Dr. William J. Stickel Annual Awards for Research in Chiropody."

The excellent scientific program was presented by Dr. John W. Witte, Chairman of the Scientific Committee.

The Board of Trustees of the American Foot Health Foundation held a conference at the meeting and Dr. Hirschberg, Chairman, reported in detail to the House of Delegates.

The Council on Education was in session for several days under the chairmanship of Dr. Max Speizman. Many other conferences were held by N.A.C. committees.

Affiliated organizations of the N.A.C. held special meetings. These were: Military Association of Chiropodists, American College of Foot Orthopedists, American College of Foot Surgeons, Chiropody Bibliographical Research Society, American Society of Chiropodical Roentgenology and the American Association of Hospital Chiropodists.

The Women's Auxiliary program was handled very capably by Mrs. Virginia Collet, National President, and Mrs. Rosalie Dikran, President of the Ohio Chapter.

A meeting of the National Conferences on Chiropodical Nomenclature of Diseases and Operations was held. Dr. Varzos conducted the meeting and the program for the immediate future was discussed.

At the first meeting of the House of Student Delegates the following were elected: President, Gerald W. Anderson; Vice President, Jack M. Schreffler; Secretary, William S. Burley; Treasurer, William A. Watson.

The following were the accredited alternates and delegates: *Ala.*, Cooper; *Ariz.*, Citron; *Ark.*, Gigerich; *Calif.*, Liss, Brantingham, Shor, Von Draska; *Colo.*, Patton; *Conn.*, Rudnick, Buchbinder, Brand; *Del.*, Baker; *D.C.*, Levin, Sollod; *Fla.*, Hurd, Marcus; *Ga.*, Noonan; *Idaho*, Kingland, Tobin; *Ill.*, Brachman, Collet, Guenzler, Rubin, Turnbo; *Ind.*, Deeley; *Iowa*, Marr, Kirkwood; *Kans.* Hargreaves; *Ky.*, Nava, Stivers; *Md.*, Ostroff, Kay; *Mass.*, Anselmi, Healy, Atkinson, McGrady; *Mich.*, Kalin, Kaplan, Mertz, Ernzer; *Minn.* Goulson; *Miss.*, Upshaw, Johnson; *Mo.*, Moros; *Nebr.*, Weiseman, Pickett; *Nev.*, Edwards; *N. J.*, Morris, Miller, Locke; *N. Mex.*, Haas; *N. Y.*, Wolfson, Marks, Eden, Sugarman, Altman, Green, Horowitz, Mullens, Werbel, Cheifetz, Weinerman, Freeman; *N. C.*, Davis; *Ohio*, Greiner, Conforti, Frost, Shapiro; *Okla.*, Johnson, Gennis; *Ore.*, Hay; *Penna.*, Dye, Egerter, Krausz, Newman, Speizman; *S. C.*, Cogen; *S. D.*, Marr; *Tenn.*, Fields; *Texas*, Dobbs, McMahan; *Va.*, Pincus; *Wash.*, Erickson, Lawson; *W. Va.*, Johnson; *Wis.*, Wichgers, Thompson.

The absence of Dr. Stickel cast a somber tone upon all the deliberations. Despite this, one left the scene of the convention exhilarated and invigorated as the result of being in contact with so many forward-looking and enthusiastic members of our profession.

RETIREMENT FOR THE CHIROPODIST

Michael V. Simko, D.S.C.
Bridgeport, Conn.

UNLESS a retirement schedule has been planned, the professional man is likely to find his declining years insecure. In this respect the factory hand is more positive about his position in the years to come.

Today's industry provides an attractive retirement program for its millions of employees. Du Pont offers a plan whereby an employee may agree to have from $12.50 to $37.50 withheld from his monthly paycheck for the purchase of U. S. Savings Bonds. Moreover, the company will invest 25% of the employee's deductions in Du Pont stock to develop a trust fund for the worker.

The automobile industry and the big steel companies provide similar interesting plans which assure future security for the worker. Some of the writer's patients are living comfortably today on a U. S. Savings Bond weekly purchase schedule which a local machine plant instituted during the war, and furthermore rewarded loyal workers at regular intervals by declaring a special bonus which was paid in U. S. Savings Bonds.

Systematic saving is one guaranteed method of preparing for independence in old age. Some practitioners make a habit of putting aside 10 or 20 per cent of their weekly income. One practitioner saves the first fee received each morning. For years the writer has made a habit of putting into a special fund every two-dollar bill received.

The money saved regularly should be positively set beyond the temptation to spend. If this saving is placed in sound stocks or bonds or in a building loan company, it is less accessible for spending than a savings account. It is generally understood that the low interest paid at savings banks promises a meager return on one's account.

An intelligent insurance program is a necessary for the professional man. Sickness or injury always poses a possible threat to the chiropodist's budget. Adequate insurance then assures an income for the individual whose revenue is interrupted by sickness or disability. Children's college education is also made certain by a purposeful insurance schedule.

Insurance, furthermore, should also be considered for future security. A straight life policy or a 30-year paid-up policy signed for early in one's career guarantees the insured an income after retirement. While an annuity policy or an endowment plan guarantees an income at a specified age, the premium price makes the plan less attractive than ordinary life; on the other hand, cash values on a policy are always greater when the premium is higher. The annuity plan, then, provides a better cash value on one's policy premium.

Dividends currently paid on most insurance policies are far from exciting when compared with the returns paid by companies a decade or more back. It seems wiser, then, for the young practitioner to sign up only for enough insurance to provide security for himself and his family. An excessive insurance schedule can easily prove so burdensome that the policyholder has no money left for certain necessities and restful vacations required for the doctor's welfare.

The advantage of an insurance program deserves consideration. An estate is made the day a policy is signed; savings are compulsory because payments must be paid on stated days; a cash value is available if an emergency arises; a loan on one's cash value is obtainable by simply

requesting same. Nevertheless, the interest rate on insurance company loans is higher than the rate demanded by local banks. Most insurance companies still exact 6% interest, whereas (using insurance policies for collateral) local banks are willing to lend money at 4 or 5 per cent.

The professional man should consider common stocks as an investment, not as a speculative plan. Public utilities, oil stocks, industries pay regular dividends on their common stock and at intervals declare extra dividends. Common or preferred stocks are bought for building a savings schedule, not for speculation.

Shares in a building and loan association, bought on a monthly plan, promise a good return. U. S. Savings E Bonds offer solid security. Interest may be allowed to accrue even after the bond matures. The Investors Syndicate, compared with similar investment companies, offers a plan of compulsory savings by selling the investor a bond which matures in a specified number of years. This bond is paid for in monthly installments. Until a few years back some of these companies paid as much as 5% interest; however, the full amount of the savings bond is not payable unless it is allowed to mature. It is advisable to understand completely the requirements before signing; certain clauses in the contract sometimes make the bond less appealing. For example, one investment company does not permit withdrawal or borrowing on the bond until after the contract has been in force two years.

Now with a financial schedule already determined upon, and with the knowledge that a Social Security check each month will lighten some of the budget burdens in later years, a plan might be studied to make the retirement years not alone profitable but useful. Statistics reveal that an active individual outlives the idle man.

The chiropodist's income declines after a certain age. When advanced years with impaired health or failing vision curtail the chiropodist's earning powers, his knowledge of shoes and foot comfort presents possibilities of a new venture. Selling shoes part time guarantees an income and keeps the retired practitioner occupied. He feels he is still a useful citizen.

A recent magazine presented a story of an elderly couple who traveled with the sun in their trailer selling shoes and realizing a gratifying revenue, while visiting about every state in the country, escaping the rigors of freezing blasts in the winter and avoiding scorching hot weather in the summer.

With his knowledge of medications, the retired chiropodist should be eligible for a part-time job in a pharmacy. The warmer states in the south offer many opportunities for the retired practitioner, but applications must be made early in the fall before the busy winter season. A study of the Florida papers usually reveals employment possibilities. Health conditions should decide the retired chiropodist on the number of hours he could devote to his new occupation.

It is also likely that the foot practitioner is not required to sever himself completely from a profession that has provided him with the comforts of life. If the operator still prefers to continue in chiropody, but does not feel equal to his customary full day, a home with an office in a suburb promises a less strenuous life, yet with a positive income. While a curtailed schedule will reduce the revenue, more time will be available for leisure, for one's family or for a hobby that's been neglected through the past busy years.

Writing promises lucrative possibilities and pleasant occupation for the practitioner who has had experience submitting articles to the chiropody journals. Short timely articles, especially the do-it-yourself type, particularly when illustrated with photographs, are always in demand by household magazines, Sunday school papers and children's monthlies. Editors are always ready to pay for articles that are simply and clearly written.

Retirement can produce a new interest or provide the time to develop a hobby that sometimes proves profitable. Several books have been written on hobbies and retirement. The following are particularly recommended: "How to Retire and Enjoy It," by Ray Giles; "Should I Retire?" by George H. Preston, M.D.; "Six Ways to Retire," by Paul Boynton; "Ways and Means to Successful Retirement," by Evelyn Colby.

A plan for retirement should be considered by the professional man. It is advisable for the young practitioner to consult a banker or a dependable insurance broker whose experience will help in suggesting a schedule to prepare for that inescapable day when the operator's hand begins to falter as the shadows begin to lengthen.

955 Main St.

THE ETIOLOGIC PATHO-MECHANICS OF SHORT LEG SYNDROME

D. R. Stouder, D.S.C.
Warsaw, Ind.

A VERY COMMON objective and subjective symptom of the patients examined for chiropodical orthopedic treatment is the short leg syndrome. Since this is a quite common condition, without a satisfactorily explained etiology, it aroused the writer's curiosity in search of a logical cause.

Relief from this condition is not difficult to obtain, but the etiological factors for its existence have been taken for granted. Diagnosis is most important, and the more accurate it is, the easier it is to treat the existing pathology. The specific cause for all mechanical pathological conditions should be put in very flexible classifications because of the many tangents of the causative factors. With this in mind, let us examine the etiology of the short leg syndrome.

Most chronic degenerative conditions develop over a long period of time. So the approach to the etiology starts with childhood, in two simple, almost unavoidable, conditions in all people that wear shoes:

1. Shoes are our enemies no matter how well they fit. That is, they cut down on the efficiency of the walking structure.
2. We all have "two-sized" feet and we wear "one-sized" shoes.

Both of these conditions need no explanation, but they cause many of the conditions we treat every day in our offices.

To simplify the explanation, the writer will use himself as a subject. He has treated himself more than the most treated patients in his office. Self-treatment should be a must for the chiropodist-podiatrist regardless of how little he thinks he needs it. Through self-treatment he is more capable of understanding what his patients experience. The writer has built more enthusiasm for his profession through self-treatment than any one thing he has ever done.

When he cast his own feet, he found the positives differed in that the right foot was 3/8 inch longer than the left, and the left foot was 5/16 inch larger in circumference. After investigation of many pairs of cases, he found almost no pair of feet identical. Ninety per cent are his type of variation. The other two classifications consist of (1) two feet the same comparative size, and (2) two feet in which one is larger in all measurements than the other.

The short leg syndrome is directly related to the difference between the two feet and the amount of adverse shoe fitting done to the feet. Many of us are lucky to have better shoe fitters than others. There are certain feet that invite more trouble from shoes than others.

An individual that has a pair of feet that are markedly different in size has the type of feet that invite trouble from shoes, and to add insult to injury, this person's shoe fitter is usually the worst he could have. It is easy to see that he is going to have more mechanical pathology than the one that has two feet more or less alike, and has better shoe fitting. This comparison provides the basis of the statement made before: mechanical etiological factors are very flexible, unlike diseases arising from a single cause.

Considering that the same proportionate difference exists in children's feet as in the adult, we can conclude that the longer of the two feet and the structures that control its function develops an entirely different pattern than the other. Each foot accumulates its abnormalities to be reckoned with in later life, or whenever the pathology becomes evident. The growing feet are more likely to become afflicted than the adult feet that have stopped growing. The degeneration in youth is more difficult to perceive because the ills have not reached the chronic state, and because the young have more capacity to counteract mechanical disease.

Applying the above few etiological factors to his own foot picture, the author well remembers a pair of shoes bought in April, which were too short when purchased. They were worn very little during the summer months and were used for school wear until the following November. He is sure that for the first forty years of his life he never had one pair of shoes to fit his feet to that degree of perfection that "one-sized" shoes can be expected to fit "two-sized" feet.

With the above malfunctioning causes, the short leg syndrome is inevitable. We will now consider the mechanical changes of each foot and leg predisposed by the fact that the feet are two sizes. Considering that the barefoot function is normal, the longer of the two feet has less length in the shoe for barefooted function to occur, and is immediately restricted in its range of motion. Restriction of motion soon brings contraction of structures, all that are used in the leg of the longer foot. Whatever happens in the foot must react in the leg because it is to the foot that the structures of the leg direct their energy.

There is no apparatus in the pelvis to allow one foot to enter the step if the other foot has not finished its step properly. The adaptability of these structures is intended for occasional adjustment to abnormal usage of a minor nature, but not constant abuse.

We will now consider the shorter of the two feet and its entrance to the step at a point where it is forced to do so, but not when it would do so normally. If you will take several of these type steps, stopping one foot short of its normal finished step and putting the other foot into

its step at this point, you will find it difficult to put this foot down without placing it in a supinated position, or at least not in normal straight-ahead manner. Ths explains the variance of the position of the two feet as they lay in a relaxed state on the leg rests of your chair. The shorter takes a more pronounced varus position than the longer of the two feet. The longer of the two feet may take a varus, straight or supinated position, the pronated position being rather rare when the short leg syndrome is present. The ability of the shorter foot to enter its step depends on the fact that it has more length in the shoe for it to function better, but it eventually has to accept the supinated entrance because the longer foot constantly forces it to do so. It slowly builds a syndrome of supination at the finish of the step, putting the pressure on the lateral side of the foot on M.P. joints 3, 4 and 5, which establishes the "flexible constant" No. 1 listed below.

The progressive supination of the leg of the short foot brings a gradual contraction of all the structures of this leg. During the formative period of the short leg syndrome the lateral structures of this leg are made longer and the medial structures contracted, but the lengthened structures do not keep their length. As the supinated leg condition becomes more chronic, restriction occurs in this leg also, due to abnormal entrance to the step and the abnormal finish that accompanies it. The loss of range of motion overcomes the length factor.

The same factors causing the short leg syndrome are the etiology of many pelvic changes which we will not discuss here. Age is not a predominant factor in making the short leg syndrome apparent, as this condition is present in young individuals.

The "flexible constants" most likely to accompany the short leg syndrome are:

1. There will be more rigidness in the first and second M. P. joints of the shorter foot than in the same joints of the longer foot. This is caused by the lack of motion and usage of these two digits at the finish of the supinated step. The rigidity of the M. P. joints of the longer of the two feet does not equal that of the first and second joints of the shorter of the feet.

2. More Morton's neuralgia is found on the short foot as more pressure is centered in that area from the supinated step. Pressure from the shoe is greater as the short foot is wider.

3. The muscles of the leg of the shorter limb are usually in a better state of mechanical health. By mechanical health, the writer means conditions that are dependent on mechanical etiology. This can be checked by several tests: comparison of the oscillometer readings of the two legs, sinusoidal and galvanic tests, digital pressure tests of the two legs. There are more varicosities present on the leg of the longer foot of the two, as a rule, and thromboses are predisposed to this leg, other than those caused by trauma.

1914 E. Center St.

URGE NON-MEMBERS TO JOIN THE N.A.C.

TREATMENT OF ACUTE TRAUMATIC BURSITIS WITH INJECTABLE HYDROCORTISONE ACETATE

Joseph Doller, D.S.C.*
Chicago, Ill.

THE PERPLEXITIES of treating the various bursitises of the foot and ankle have certainly reached each and every one of us. In approaching the treatment of this condition, we find that there are several acceptable techniques offered the practitioner. We have found, however, that when a great number of techniques are associated with a specific entity, each of these techniques must have some shortcoming. The application of a new technique is an interesting phase of practice but our natural goal must be to find a specific treatment for each entity. In approaching the problem of bursitis of the foot and ankle, it is our intention to have this paper serve as a step in that direction. Although no claim is set forth as this being THE answer, it is felt that the technique presented herein has potentialities for becoming a specific for the treatment of acute traumatic bursitis of the foot and ankle.

This paper will deal with acute traumatic inflammatory bursitis. It will not differentiate between superficial or deep bursa, but mention must be made that the deep bursa are functionally more important and usually communicate with a joint space. This infers, when approaching a deep bursa, the same precautions must be taken as in a joint approach.

The manifestations of the disease indicate the etiology is directly related to trauma (single or multiple, direct or indirect), or acute, or chronic systemic infection.

In the acute inflammatory stage, the condition follows a typical pattern and the diagnosis should not be too difficult. We find a local area of pain, bursal effusion, edema, tenderness, with a limitation of motion. The effusion is of a serious nature, rarely hemmorrhagic due to the minimal vascular supply to the bursa proper. Before administering treatment, a careful differential diagnosis must be made to rule out fracture, periarticular tears, or infectious processes.

The bursae of the foot and ankle are basically buffers of nature. They act as the shock absorbers during acts of motion and weight bearing. Bursae are generally found between two or more bones, or between bone and its adjacent soft tissue, usually tendon or ligament. We will find bursa at many of the points where tissue of one type or function overrides another. It becomes apparent that friction between these two or more bodies must be either controlled or eliminated. On examining the anatomical patterns, we find that the foot and ankle are supplied with a multitude of bursal structures. The occurrence of the bursae presents a most interesting picture. We are born with a primary bursal system but as we continue to grow and increase our functions, the foot in particular develops additional or secondary sacs. So in addition to the natural bursae in the foot and ankle, which can be classified as true or anatomical bursae, we have the added or late starters commonly referred to as adventitious bursae.

Approximately two years ago the use of various injectables became a part of the armamentarium of our athletic training room. Because acute

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traumatic lesions are the prevalent conditions, our search in therapies was in that direction. A thorough examination was made on drugs in this category. As time progressed we eliminated individual drugs and finally came upon one drug that we felt showed the most promise for this work. The drug of choice is a saline suspension of hydrocortisone acetate.†

As with every new concept of chiropodical medicine, a definite routine was established to ascertain specifically the results of the medications employed. A careful program was laid out whereby the hydrocortisone acetate was employed for all soft tissue trauma, especially the ten most common bursae of the foot and the five most common bursae of the ankle. In addition to the known bursal areas, signs indicating the possibility of an adventitious bursa being present were also treated as a true bursitis. All trauma cases were first subjected to X-ray evaluation to rule out fracture.

Entering the realm of treatment, our approach to this problem was to employ paracentesis. This enables us to expect a successful prognosis in these traumatic lesions. In treating this lesion, it is best to remember that the effusion must be readily absorbed by the endothelial lining of the bursal sac. Without this physiological activity taking place in the acute stage, we must eventually be faced with a chronic or latent type bursitis.

The materials needed to carry out a joint paracentesis for acute traumatic bursitis in the foot or ankle are:

1. Antiseptic solution.
2. Sterile gauze and dressing.
3. A 2 to 5 cc. syringe, depending upon the joint size.
4. Solution of procaine HCl for anesthesia.
5. Vial of saline suspension hydrocortisone acetate (each cc. equals 25 mg.).
6. A 20-22 gauge needle, length depending upon site.
7. Small piece of sterile airfoam sponge or rubber.
8. An elastic pressure bandage.

Doing a joint paracentesis is a comparatively simple procedure. The prime object is to pierce the sac with minimal amount of pain and trauma. Above all else, care should be taken to introduce no infection into the joint.

Techniques of joint paracentesis have been offered whereby aspiration of the joint was first done before injection of solution. In treating the foot, it is seldom, if ever, necessary to aspirate, due primarily to the smallness of the joints. The size of the sac rarely indicates such procedure. However, one occasionally finds the aspiration of the ankle joint a necessity. Inasmuch as this paper deals with trauma in the acute stage, a laboratory workup would not be done should we decide to aspirate.

Following the diagnosis, the site of injection is selected. Usually the extensor surface offers the most accessible point. In the selection of the site for injection, the operator should seek a pathway avoiding major nerves and vessels.

The area is cleansed and made sterile with antiseptic solution. Anesthesia is accomplished with the use of 1-2% procaine HCl or by topical application of Ethyl Cl. spray. In some cases the combination of procaine

†Hydrocortone Acetate (Merck).

HCl with the hydrocortisone acetate, mixed thoroughly in the syringe, was administered. In other instances, no anesthesia was employed. As to the amounts to be used, we have found the dosage listed here to be most satisfactory.

1.	Metatarsal phalangeal joints	1/5 to 1/2 cc.
2.	Tarsal-metatarsal joints	1/4 to 3/4 cc.
3.	Tarsal joints	1/2 to 3/4 cc.
4.	Ankle joint (Bi-malleolar)	3/4 to 1 cc.

It is suggested that not more than three consecutive injections be made in one week's time. These injections can be spaced approximately two (2) days apart. If by the time of the third injection, considerable improvement has not been made, a change in therapy is indicated. The promiscuous use of the drug is not recommended.

When entering an area where the sac is distended, the feeling of "being in" is easily obtained. The feeling of puncturing the sac is similar to the puncturing of a balloon with a needle. In attempting to puncture a sac with little or no distention, we sometimes have trouble. With some practice, this difficulty can be easily overcome. Once the needle has pierced the sac, the operator will sense it by the reaction of the patient as well as by the loss of resistance. The suspension is then deposited in the sac and the needle withdrawn. A sterile gauze pad is then placed over the site of injection. On top of this is placed a square piece of airfoam sponge or rubber. The size of the airfoam pad should be approximately the size of the sterile gauze pad. The foot or ankle is then wrapped with an elastic pressure bandage. The patient is then instructed to continue activity and do as much walking as possible. As the activity increases, the process of inflammation should begin to subside.

The main thought of this paper is to present a simple operable procedure to the practitioner. With the ever-increasing public participation in physical activity, so increases the incidence of traumatic lesions. The patient, whether he be of the athletic or sedentary type, suffers the same pain and desires the same rapid recovery. The technique presented herein has, in our hands, after a fair trial, proven to be of considerable merit.

4403 Sheridan Road

AN EVALUATION OF RESULTS OBTAINED THROUGH SURGICAL AND NON-SURGICAL THERAPY IN HALLUX VALGUS AND HALLUX RIGIDUS

(Continued from Page 31)

and the outer side of the head of the first metatarsal. The contour of the head of the first metatarsal appeared irregular, thereby making the first metatarsophalangeal articulation somewhat narrowed. There was also some displacement of the sesamoids laterally to a moderate degree.

No other important joint pathology was noted, so it was concluded that the rigidity was due to fibrous adhesions.

The first three treatments by the traction machine (Budin) were followed by whirlpool. Subsequent traction treatments were followed by sinusoidal wave currents. Intervals of treatment were about four days. As the motion increased, pain in walking gradually diminished. Her

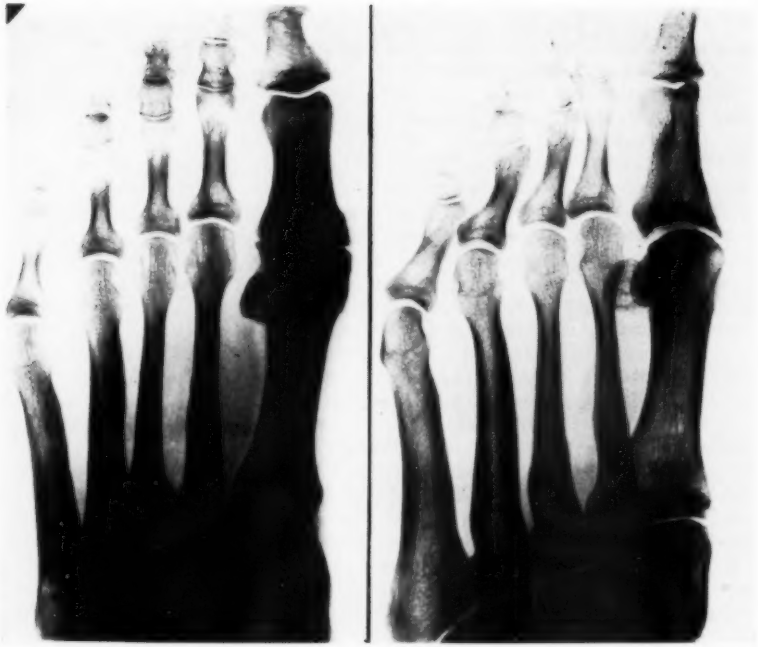

Fig. 3—Shows a broadening of the shafts of the 4th and 5th metatarsals, and a thinning of the shafts of the second and third metatarsals. Also a narrowing of the 1st metatarsophalangeal articulation.

old shoes suddenly became very comfortable, the "bare" spot on the sole of the shoe under the first metatarsophalangeal joint showed weight-bearing and finally, after twelve treatments, it was difficult to tell which joint had been involved.

The marked thickening of the fourth and fifth shafts showed Wolff's law in action. "Every change in the form and function of the bones, or of their function alone, is followed by certain definite changes in their internal architecture, and equally definite secondary alterations of their external conformation, in accordance with mathematical laws."

Conclusion

1. Surgery has no place in the treatment of hallux rigidus because the results have been so poor. This is particularly conspicuous in those cases associated with an elevated first metatarsal (metatarsus primus elevatus) in cases of generalized arthritis or in adolescent cases.
2. As reported by the author, traction therapy, using anesthesia of the joint, if necessary, is the treatment of choice.
3. Cortisone locally shows promise and may prove to have great value in hallux rigidus.

1900 Albemarle Rd.

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TECHNIQUES FOR SUCCESSFULLY PROCURING LEGISLATION

Morris Haas, D.S.C.
I. Michael Gross, D.S.C.
Albuquerque, N. Mex.

HAVING SUCCESSFULLY completed our own legislative program, we wish to impart the knowledge and techniques which we have learned in this endeavor. The primary task is one of education. You must teach the background of the modern chiropodist to everyone you meet. Do not worry about limits on what we can do or cannot do. If you successfully impart our educational background and name the subjects which the modern chiropodist has at his disposal, there is no limit to what the educated legislator is willing to have us do—as long as what we request is for the benefit of the public as a whole, and for their protection.

These following salient points were only learned through much time and effort.

1. Obtain expert legal counsel to properly phrase and compile the proposed statute.
2. Endeavor to obtain the support of the State Societies of Medicine and Osteopathy through their respective legislative committees.
3. If possible, have a legislator who is familiar with chiropody to introduce the proposed legislation.
   (a) By all means be certain to educate the legislator as to the background, prerequisites, modern chiropody education and the scope of practice of the modern chiropodist.
   (b) As this man is the speaker for your profession in the official legislative body, he must be able to stand and answer all questions on the subject.
4. Send a final draft of the bill to all legislators at the earliest possible date and ascertain that the time is definitely prior to the convening of the legislature.
5. Have all members of the Association contact their legislators informing them of the scope and purpose of the legislation. If possible educate them to chiropody in general. This is best done by personal contact.
6. Ascertain through your legal counsel and your legislator the proper time for introduction.
   (a) We found that early presentation was advantageous.
7. Personally contact the chairman of the committee to which the bill is assigned.
   (a) Arrange for a hearing before the committee for your entire legislative committee.
   (b) Assure the chairman that your hearing will be brief, and then make certain that you do hold your personal remarks for a four-minute limit. In closing your remarks, invite questions from the committee. Answer these specifically, and with statistics, if possible.
8. Have representatives present in the chambers when the bill is under discussion, so that if your legislator does need data, it will be readily available. Your legislator does have the power to ask that the legislative body be resolved into a "committee of the whole" at which time your chiropody representative may speak and answer questions.

9. After the bill has passed one house of the legislature, immediately use point 7 for the other legislative body.

(a) It is not improper to make changes in this committee before passage by the second house, provided that said changes are not so controversial as to endanger concurrence by the first house after passage by the second house.

10. Have your State Board and/or Legislative Committee of your Association visit the Governor to assure him that the bill has the approval of the Association and the Board and that the bill is for the protection of the public.

We wish to stress that all legislation should be introduced primarily for the protection of the public and secondarily for the benefit of the profession. Although chiropody is becoming better known, most people are not aware of the education of the modern chiropodist. The reason for increasing the scope of practice is that we can therefore be of greater value to the public. Regardless of the scope of your legislative program, it will take great preparation, so do begin early.

1301 Central Ave., East
205-A Truman, N.E.

EXCERPTS FROM LECTURE DELIVERED BY SAYRE, M.D. AT BELLEVUE COLLEGE HOSPITAL, IN THE YEAR 1876

"GENTLEMEN: The amount of agony and torment suffered on account of corns, bunions and ingrowing toenails, is all the apology I can offer for bringing these subjects before you. Our business, as surgeons, is to relieve human suffering if possible, no matter whether it comes from a corn or cancer. There is a widespread opinion that the general surgeon knows nothing about corns, or, if he does, that he regards it beneath his dignity to undertake their treatment; therefore patients go to some chiropodist to get their corns taken care of. One of the greatest insults ever offered to my professional ability was given by a gentleman, whose family physician I had been for many years, when he remarked with a scowling face and snarling voice, 'A storm is coming; I must go to my corn-doctor and get my corns fixed.' I asked him how he could trust his life and that of his family in my hands if he did not think I was capable of taking care of his corns? He replied that he was ashamed to ask me to look at his corns, as he did not think I would stoop to notice a corn.

No, gentlemen, I do not feel it beneath my dignity and I hope you will never consider it beneath yours, to stoop to do anything that will relieve human suffering. A corn is infinitely more painful than a cancer, and is capable of inflicting torment sufficient to destroy the sweetest disposition, and upset the best-regulated families. This is no fancy sketch of mine, for, without exaggeration, it can be practically demonstrated that entire families have had their peace and comfort destroyed for years, because one of their members had been tormented with inflamed corns. I have one family in mind now (the gentleman's just referred to) in which domestic turmoil was the rule rather than the exception, and continued so for years, until the senior member got his corns cured. So great was the change in the disposition of that man, that one of his family remarked,

'We really believe that father is becoming religious,' simply because peace and quiet have been restored to the household in consequence of his being relieved of the pain produced by his corns, and he and his family have been happy ever since.

Now, what is the nature of these tormenting formations? A corn is simply a localized hypertrophy of the skin, caused by abnormal pressure. These hypertrophied epidermal and dermal layers become like dry scales or shells, with a central point of hardening, which is called the "core" of the corn. This little concretion dips down and presses upon the nerves beneath like a sharp-pointed instrument, and produces indescribable torment.

There are two varieties of corns, the hard and the soft.

The soft corn is excessively tender, and is much more liable to become inflamed than the hard corn. This variety is more frequently found between the toes than elsewhere.

The hard corn has already been described.

As before remarked, the cause of corns is abnormal pressure, which may be continuous or intermittent, and in general is produced by bad shoeing. The shoes, instead of being sufficiently wide at the toes and across the ball to permit perfect freedom of motion at the metatarsophalangeal articulation, so that the foot may expand to its full extent with every step, are made so narrow that undue pressure is brought upon certain points not intended by Nature to receive it, therefore, not properly protected, and corns are developed. The irritation produced by pressure upon these formations may give rise to reflex muscular contractions, which will draw the toes up, and it is not at all uncommon to see a row of corns over the second phalangeal articulation, caused by the elevation of these joints against the shoe from this reflex muscular contraction.

How Are Corns to be Treated?

In the first place, you must insist upon the patient wearing properly-constructed shoes. Shoes must be worn which will permit expansion of the foot in all directions at every step, and then corns will never be produced; but, if they have been formed, we must treat them. You begin by paring the corn, carefully removing the hard shell with a sharp knife as much as can be done *without drawing blood*. When that is done, rub the surface of the corn with a solid stick of nitrate of silver; this will remove within a few days an additional layer of hardened tissue, which cannot be done with a knife without drawing blood. Now the corn is ready to "collar" with adhesive plaster. This is done most conveniently by taking narrow strips and building a "cob-house" around the corn, carrying it up until sufficient elevation is obtained to completely protect the corn from pressure.

For the soft corn, the application of nitric acid (concentrated), or the solid stick of silver nitrate, is the most serviceable treatment that can be adopted.

First remove, by means of a knife or scissors, the thickened skin which covers the corn; then wipe the parts dry and apply the acid or the nitrate of silver. These first applications are somewhat painful, but they are also exceedingly beneficial. After the application has been made, place a pledget of cotton between the toes so as to permit the free entrance of air. In a few days the dry and hardened skin caused by the caustic can be

easily removed with the forceps and a second application made if necessary. This second application is not generally painful, unless done too early, and very seldom has to be repeated.

The reflex muscular contraction excited by a row of corns, upon the top of the toes, along the second phalangeal articulation, is sometimes so great as to produce a subluxation of all the metatarsophalangeal joints. Sometimes such crooked deformed toes can be harnessed into the normal position by strapping them to a level surface with strips of adhesive plaster. It frequently happens, however, that this cannot be done; if it cannot, then subcutaneous section of the contracted tendons will be necessary.

Bunions: A bunion is an enlargement and inflammation of the bursa situated upon the side of the great toe, at the metatarsophalangeal junction. Inflammation of this bursa is frequently so severe that the reflex contractions which follow produce a subluxation at this joint. In consequence of the subluxation, the phalanx is made to press against the nerve that supplies this portion of the great toe to such an extent as to produce the most exquisite and torturing pain.

This condition of affairs can be easily relieved by taking a strip of adhesive plaster and commencing between the great toe and the one adjoining, carrying it over the end of the toe, adjusting it, and then continuing the plaster along the inner side of the foot, around the heel, and as far back as the base of the fifth metatarsal bone, where it is firmly secured with another strip of plaster and a roller-bandage.

It is usually necessary, before applying the long strips of adhesive plaster, to place one or two thicknesses of the plaster just before and behind the bunion, to make a little elevation before passing over the great-toe joint. It is occasionally necessary to divide the tendon of the extensor proprius pollicis which has been long contracted, before the toe can be placed in its normal position.

In several instances under my own observation, these bunions have gone on to such an extent as to produce periostitis, and ending in caries of the joint. Under such circumstances, exsection was resorted to with complete success. In some cases the great toe becomes so everted and drawn over the end of the adjoining toe that it cannot be brought *immediately* into position and retained by the adhesive plaster as above described.

In such cases it is necessary to apply a tractile force that by its constant action will in time overcome the deformity after which it is easily retained in position by the simple dressing before referred to.

To do this, a buckskin or linen glove can be made to fit the toe, and to this attach a few inches of elastic webbing, which is again attached to a piece of adhesive plaster to go around the foot, and is retained in place by two other pieces, as seen in Figs. 92 and 93, photographed from a patient of Dr. Chas. H. Lathrop of Lyons, Iowa, and which give a very good idea of the deformity and the mode of treatment.

Ingrowing Toenail: The most prolific cause of this difficulty is wearing narrow-soled shoes and boots. That class of people who will insist upon wearing narrow-soled shoes, on the supposition that such shoes and a high instep are elements of great beauty, will sooner or later become cognizant of the fact that ingrowing toenails are their legitimate off-

spring. Such abnormal pressure causes the nail to cut its way into the tissues; the consequence is, the tissues surrounding it become hypertrophied, and very commonly a large mass of granulations spring out from the side of the nail.

The first thing to be done in the way of treatment is to guard these fresh granulations from the pressure of the sharp cutting edge of the nail, which can be done by placing a layer of cotton between them. The proper instrument to perform this operation with is a narrow thin blade without a cutting edge. (See Fig. 94.) Double a few threads of cotton over the instrument, and then carefully carry it down between the granulations and the nail until the edge of the nail is reached, when the instrument is gradually turned flatwise and carried beneath it.

Sometimes it becomes necessary to remove the granulations with the scissors; nitric acid is an excellent application, and nitrate of silver is nearly as good. After the application of the cotton, therefore, the granulations should be brushed over with the acid or silver. As soon as the layer of dead tissue made by the caustic application is ready to fall off without producing hemorrhage, it may be removed together with the cotton fibres, and the cotton again introduced. The second application of the cotton is not, as a rule, very painful. The granulations are then to be brushed over with the caustic, and when the layer of dead tissue again separates, the dressing is to be renewed. This treatment should be continued until the nail has had time to grow out and protect the tissues by its own presence, and retain them in their proper position. The nail is there for the protection of the flesh, and if improperly cut, in addition to the abnormal pressure made by improper shoeing, serious trouble will be much more readily produced. The nail should always be cut squarely across, so as to leave the corners, altogether free from the flesh, and permit them to act as a shield for its protection.

A very common method of treatment is to recommend the patient to go to some specialist on corns and toenails, but you ought certainly to be able to treat them yourselves.

Another plan of treatment is to cut a gutter in the center of the nail, which has a tendency, it is said, to elevate the corners. Still another plan is to divide the nail and then strip it off. This operation must be repeated in a short time unless the matrix is also removed.

All these plans of treatment have received the approval of the profession, and some of them have been extensively practiced; but I believe the better plan of treatment is that which I have indicated; at all events, removal of the nail should never be resorted to unless hypertrophy of the tissues about it has gone to such an extent as to make it impossible to repair the parts without removing the cause of irritation. If the nail is removed, it is necessary to remove the matrix in order to prevent the return of the nail.

Supernumerary Toes and Fingers: I call your attention to this class of deformities, almost solely for the purpose of impressing upon you the importance of their early correction.

All such deformities should be attended to before the child arrives at an age when they will produce any mental impression. If permitted to remain until the child is old enough to recognize them, they are ever afterward a source of mortification, and, in some cases, produce such mental agitation as to be the cause of alarming nervous symptoms.

The very fact of being conscious that the feet or hands are not like those of other children may be sufficient to ruin the child, unless the deformity is removed, thereby relieving him of the self-accusation of his deformity, and the constant observation and taunting of those with whom he may be associated. An example of the influence which such deformities may have upon the nervous system has been already given in my third lecture. These deformities can be much more easily corrected while the child is young; growth obliterates very many of their effects, and the mental impression which they are liable to produce will in that way be avoided."

Submitted by Dr. M. Becker, 51 E. 42nd St., New York, N. Y.

BOOK REVIEW

CLINICAL ORTHOPAEDICS, by *Anthony F. DePalma,* Editor. 240 pages; illustrated. J. B. Lippincott Co., Philadelphia, Pa., 1954. Price $7.50

This is the fourth of a series of publications which is sponsored by the Association of Bone and Joint Surgeons. To be fully appreciated, it must be remembered that each volume represents only a limited part of a long-range plan designed to provide an outlet for orthopedic material of interest and to augment other channels of literature.

The book is divided into a section on joint fractures and dislocations and one on general orthopedic subjects. In general each subject is well presented, adequately illustrated, and where applicable, followed by an excellent bibliography. One who keeps abreast of current literature may be justly critical of the two articles on fractures of the patella which add little to this subject. Garrett Pipkin uses seven pages to discuss dislocation of the carpal lunate and a presumptive test for reduction. He deemphasizes the value of good roentgenography in the management of this injury. Juan Farill describes still another method of treatment of congenital dislocation of the hip and admits the inadequacy of follow-up studies in his patients. Francis W. Glenn's article on the antibiotics and chemotherapeutic drugs, and Harry C. Stein's discussion of preservation of foot function are excellent. These two articles are both highly informative and thought-provoking and will probably be read and reread with great interest by all who may have access to them. W. M. Deyerle and V. R. May present an excellent discussion of the sciatic nerve syndrome and describe a new and simple test which should prove to be a useful adjunct in the diagnosis of this condition.

As in the case of each of the preceding publications of this series, this volume complements the editor's plan and justifies a place for this type of publication in the field of orthopedic literature.

—ALFRED A. GREBE, Col., MC, USA

PARTICIPATE IN YOUR
STATE AND LOCAL
CIVIL DEFENSE PROGRAM

ABSTRACTS AND HEALTH NEWS

GAIT AFFECTED BY BONE TWISTS

CERTAIN TWISTS in the leg bones, developed during the years when children are learning to walk, largely determine the gait or characteristic way in which a person walks, it appears from studies reported by Dr. Herbert Elftman of Columbia University in the American Journal of Physical Anthropology, October, 1945.

The bones making up the upper and lower parts of the leg develop their twists independently, if you "toe in," the combination of these twists are in one direction; whereas, if you "toe out," the twists are in the opposite direction. Scientists, especially orthopedists, are interested in learning how each leg bone affects walking, because this knowledge is useful in correcting bad foot posture.

It is almost impossible to measure the twists in a leg bone during life, even with the X-Ray. Dried bones are not entirely satisfactory either, because it is impossible to tell at what angles they were connected with one another. For example, if you straighten your leg and try toeing in and out, you will notice that the whole leg from the hip downwards turns with the foot. Thus it is necessary to study the leg as a whole. To solve this problem Dr. Elftman resorted to studying legs that have been taken off at the hip. All that he needed to do in such cases was to expose enough of the joints at the hip, knee and ankle to determine their axes. From the angles which these joints make with a standard plane he could determine the amount of twisting in each bone.

From Dr. Elftman's findings, there appears to be little relationship between the twist in the thigh bone and that in the lower leg bones. On the other hand, the twisting of the lower leg bones as seen in the ankle joint has a definite relationship to foot position. Dr. Elftman points out also that the twists in the adult bones are quite different in degree from those present at birth. Although the evidence is incomplete, it seems to indicate that the adult condition develops during the years when children learn to walk.

PHYSIOLOGY AND TEMPERAMENT

IN 1884 Jonathan Hutchinson started a series of lectures with the following sentences: "Our forefathers, who knew far less about the detail of pathology than we do, attached far more importance to such matters as temperament and diathesis. They were accustomed to prescribe for a man's temperament; we think only of his disease, and turn aside with weariness from classifications of diathesis in which the physicians of an older day delighted. Although to a large extent this change of sentiment has been the result of advance in knowledge, yet I think it might easily be shown that it has gone too far, and that we now neglect unwisely the study of those differences between man and man of which, for the most part, physiology takes no cognizance, but which may yet prove of much importance in modifying the processes of disease."

I. B. Sneddon, "The Mind and the Skin," Brit. M. J., March 19, 1949, p. 472.

A LETTER TO THE EDITOR

I AM WRITING this letter with particular reference to the article, "Get Acquainted with Your Shoe Repairman," which appeared in the June (1955) issue of the N.A.C. *Journal.*

While in chiropody college in Chicago, I thoroughly digested the contents of each issue. How the above article was incorporated in the June issue is not comprehensible.

After thoroughly enjoying such articles as Dr. Rubin's on Hydrocortisone and Dr. Schecter's interesting notes on the application of low voltage therapy, the article by Dr. Dixon seemed out of bounds and irrelevant.

The *Journal* is, supposedly, a gathering of choice scientific data which should enlighten the practitioner and keep him abreast of the times.

The shoe repairman has a trade in which he is proficient. However, it seems rather incredible that the chiropodist (who is not a layman) would entrust the casting for appliances, braces, etc., without instruction to laymen. The doctor should prescribe the shoe alterations, and the shoe repairman should carry out his wishes.

In this manner, the doctor fulfills his obligation to the patient, and retains patient control, at all times. The article by Dr. Dixon fails to leave this impression with the reader.

Respectfully yours,

Joseph R. Cinzio, D.S.C.
220 Lexington Avenue
Passaic, N. J.

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ORGANIZATION NEWS

NEW JERSEY

Hudson County Division

THE HUDSON COUNTY DIVISION of the New Jersey Chiropodists' Society will hold its 1955-56 meetings at the Pollack Hospital, 90 Clifton Place, Jersey City, N. J. All lectures will start promptly at 9:00 P.M., except the joint meeting with the Eastern Division which will be held at 7:30 p.m.

The committee has endeavored to provide a well-diversified program and has succeeded in securing members of the profession who are eminently qualified to present their subjects.

The following are the dates and subjects: September 13, 1955, "The Contact Sandal," Dr. Samuel Rosoff; October 11, 1955, "The Art of Practice," Dr. Raymond K. Locke; November 1, 1955, dinner and meeting to be held jointly with the Eastern Division at the Essex House, Newark, N. J., at 7:30 P.M.; December 13, 1955, "Clinical Use of Drugs," Dr. Marvin D. Steinberg; January 10, 1956, "Complete Foot Rehabilitation," Dr. M. M. Polokoff; February 14, 1956, "A Review of Verruca Therapy, Dr. Samuel Brezak; March 13, 1956, "Office Shoe Molding for Men, Women and Children," Dr. Herman Tax; April 10, 1956, "Application of Low Voltage Therapy in Neuromuscular Disease," Dr. Joseph M. Horwitz; May 8, 1956, "Chiropodical Roentgenology," Dr. H. B. LeVine; June 12, 1956, "Routine Office Surgery," Dr. Milton E. Ashur.

The program is under the direction of Drs. Anthony R. Grieco, chairman, and Alvin Hollenberg, co-chairman.

Eastern Division

The Eastern Division of the New Jersey Chiropodists' Society held its first meeting of the season on Tuesday, September 6, 1955, at the Academy of Medicine in Newark, N. J., at 8:15 P.M. Dr. Murray Bromberg spoke on "simple office tests used to aid in finding existing pathologies and correction of weakfoot." The lecture was illustrated with slides and x-rays

Dr. Samuel Max, scientific chairman, arranged the above and also the following program for the coming year: October 4, 1955, (first lecture), December 6, 1955 (second lecture), January 3, 1956 (third lecture), February 7, 1956 (fourth lecture) of a "Course in Chiropody Diagnosis," by Dr. Marvin Steinberg; November 1, 1955, dinner and meeting in conjunction with the Hudson Division at the Essex House, Newark, N. J., at 7:30 P.M.; March 6, 1956, "What's New in Medication," Dr. Harry Goldwag; April 3, 1956, "Hydrocortisone Therapy of the Feet and Ankle," Dr. Albert Wilner, orthopedic surgeon; May 8, 1956, "Practical Economics," Dr. George Deyo; June 5, 1956, "Practical Office Surgery," Dr. Abe Simon.

PENNSYLVANIA

Western Division

THE FALL MEETING of the Western Division, Chiropody Society of Pennsylvania, was held on Thursday, September 8, 1955, at the Mellon Institute in Pittsburgh, Pa. The speaker of the evening was Dr. Raymond Goldblum, dermatologist, who lectured on "Dermatology of the Feet." The following officers were elected for the ensuing year: Dr. Mark Levin, President; Dr. James Conway, Vice President; Dr. Ed. Bleier, Secretary-Treasurer.

VERMONT

THE VERMONT CHIROPODY ASSOCIATION held their annual meeting at the Hotel Coolidge in White River Junction on May 12, 1955. The following officers were elected:

President, Dr. R. M. Coburn
Vice President, Dr. W. G Weatherhead
Secretary-Treasurer, Dr. Regis Nolin

The next meeting will be held at the Hotel Coolidge in May, 1956.

MARYLAND

AT THE RECENT annual meeting of the Maryland Chiropody Association, the following officers were elected:

President, Dr. V. S. Cantrell
Vice President, Dr. I. H. Samuels
Secretary, Dr. M. D. Fielding
Treasurer, Dr. R. J. Hill
N.A.C. Delegate, Dr. J. J. Ostroff
N.A.C. Alternate, Dr. E. J. Kay
N.A.C. Council Member, Dr. E. J. Kay
Executive Board Members, Drs. Kay, LeBow and Mahler

MEMBERSHIP APPLICATIONS

State Society Secretaries and Membership Chairmen are urged to send applications for membership promptly to the N. A. C. Please make every effort to speed up processing the applications.

KANSAS

AT THE APRIL MEETING, the Kansas State Chiropody Association adopted a new Constitution and Code of Ethics. The following officers were elected: President, Dr. L. E. Krause; Vice President, Dr. D. M. Miller; Secretary-Treasurer, Dr. J. M. Comstock; Board of Directors, Drs. H. R. Stone, Myron Fox and F. B. Sargent.

The Kansas State Chiropody Association will meet October 8-9, 1955, in Salina, Kansas. Dr. Howard Chapman of Shreveport, La., will be guest speaker. He will lecture on the following subjects: Office Procedure with Enthusiasm; Physiotherapy with a Purpose; Chiropodical Surgery; and Children in Chiropody (Case History).

A.S.C.R. POST GRADUATE COURSE 1955

FOR THE first time in the thirteen-year history of the American Society of Chiropodical Roentgenology, a complete and comprehensive post graduate course in roentgenology, covering five full-day Sunday sessions, is scheduled to begin on October 2, 1955, at the Hotel Astor in New York City. The balance of the dates are: October 23rd, November 13th and 27th, and December 11th. The time will be from 10:00 A.M. to 12:00 A.M. and 1:00 P.M. to 4:00 PM.

The course will include theory, as well as actual demonstration of x-ray pathology, and will cover both technique and interpretation. Qualified instructors from among the Fellows of A.S.C.R. will cover every phase of the subject, thinking constantly of how you may correlate the information in your daily practice.

Because of the many requests for such a course, the society feels that the limited number of registrants will be quickly enrolled. This will be your only notification. Address inquiries to: Joseph Gilden, D.S.C., F.A.S.C.R., Secretary, Community Building, Fairfield, Conn.

REGION THREE CONVENTION COMMITTEE

DR. BERNARD C. EGERTER of Pittsburgh, Pa., has been appointed general chairman of the 1956 Region Three Convention of the National Association of Chiropodists to be held April 12, 13, 14 and 15, 1956.

The zone managers of the state chiropody societies of Delaware, Maryland, New Jersey and Pennsylvania, component members of Region Three, selected Dr. Egerter, who will meet with them in Atlantic City in the near future for preliminary discussion of arrangements for the conclave.

Dr. Egerter succeeds Dr. Jonas C. Morris, who has been general chairman of the Region Three convention for the past six years and is now vice-president of the National Association of Chiropodists.

Another change in the executive branch of Region Three is the appointment of Dr. Joseph F. Brown of Newark, N. J., by the New Jersey Chiropodists' Society, succeeding Dr. Joseph Funston of Atlantic City, who recently retired after outstanding service as the New Jersey state manager for six years.

The newly appointed Region Three Convention Committee for 1956 as selected by Dr. Egerter is as follows: Dr. Arthur M. Schultz, Pittsburgh, Pa.; Dr. Charles E. Krausz, Philadelphia, Pa.; Dr. Joseph F. Brown, Newark, N. J.; Dr. Jack Horwitz, Burlington, N. J.; Dr. Lee Lindenberg, Lansdale, Pa.; Dr. William B. Ignatoff, Newark, N. J.; Dr. Jack J. Ostroff, Baltimore, Md.; Dr. James E. White, Wilmington, Del.; Dr. Joseph M. Funston, Atlantic City, N. J.

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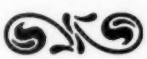

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LOW VOLTAGE SOCIETY TO HOLD ANNUAL MEETING

THE AMERICAN Chiropodical Society of Low Voltage will hold its Annual Business and Scientific Meeting at the Roosevelt Hotel in Pittsburgh, Pa., on Saturday and Sunday, October 22nd and 23rd.

The business meeting will take place on Saturday afternoon at 2:00 P.M. and a full day of scientific lectures will be presented on Sunday, starting at 8:30 A.M. and continuing until 4:00 P.M. Members of the National Association of Chiropodists are welcome to attend the scientific portion of the meeting which will consist of presentations by three outstanding men in the field of Low Voltage.

Further information can be obtained from Dr. Walter Teskey, registration chairman, 208 Empire Building, Pittsburgh 22, Pa.

The program will be announced later.

FEDERATION OF CHIROPODY BOARDS HOLDS TWENTIETH ANNUAL MEETING

THE FEDERATION of Chiropody Boards held its Twentieth Annual Meeting in Cleveland, Ohio, August 14, 1955. The Federation adopted the new bylaws similar to those of the Dental State Board organization.

For the coming year, the Federation will evaluate all old State Board questions possible and those from the chiropody colleges.

The Federation will also continue its work in studying the possibilities of a National Chiropody Board.

The following officers were elected: President, Dr. G. R. Tobin, Twin Falls, Idaho; President-elect, Dr. C. L. Meyer, Galesburg, Louisville, Ky.; Vice President, Dr. C. H. Turner, Quincy, Mass.; Secretary-Treasurer, Dr. L. A. Hansen, Kansas City, Mo.

Dr. E. W. Dobbs of Houston, Texas, was elected to represent the Federation on the Council of Education of the National Association of Chiropodists.

The Federation of Chiropody Boards is extending associate membership to former members of chiropody boards in the United States and Canada. This is being done in the Federation of other professions. Associate members will receive the following benefits: (1) Receive four issues of the Federation Bulletin each year; (2) Be listed and receive the annual directory which is sent out about Dec. 1st; (3) Receive a certificate of Associate Membership; (4) May attend the annual meetings but have no vote; (5) Receive a copy of the new bylaws of the Federation of Chiropody Boards.

For further information write to Dr. L. A. Hansen, 800 Professional Building, Kansas City, Mo.

ALPHA GAMMA KAPPA FRATERNITY HOLDS ANNUAL MEETING

THE ALPHA Gamma Fraternity held their annual convention in Cleveland, Ohio, at the Statler Hotel immediately following the N.A.C. Convention. The host Chapter was Kappa, which is located at the Ohio College of Chiropody in Cleveland. The convention was managed by Joseph Sweeney of Kappa Chapter.

In addition to delegates from the active school chapters, there were delegates from the Texas Alumni Club, the Oklahoma Alumni Club and the Chicago College of Chiropody. The Alumni Clubs were

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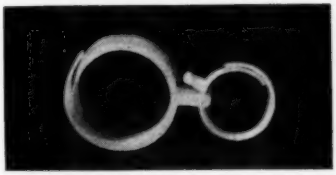

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represented by Dr. Roberts of Texas, Dr. Haux of Oklahoma and Dr. Durkin of the Chicago College.

Officers elected for the current year were: Dr. B. C. Egerter, Pittsburgh, Pa., National President; Dr. Erwin Wunderlich, Miami, Fla., National Secretary; Dr. Charles A. Roberts, Sherman, Texas, National Treasurer.

The Executive Council of Alpha Gamma Kappa appointed Dr. C. A. Roberts as Executive Secretary for a three-year period. The address of the Executive Office will be P. O. Box 760, Sherman, Texas.

Epsilon Chapter of Chicago College of Chiropody will be the hosts for the 1956 Convention which will be held in Chicago, Ill.

CALIFORNIA COLLEGE OF CHIROPODY—NINTH ANNUAL SEMINAR

The California College of Chiropody announces that Dr. Marvin Steinberg of New York City has been chosen to be the guest speaker at its Ninth Annual Seminar. The college will present the Seminar in Seattle, Wash.; San Francisco and Los Angeles, Calif. This will be the first entry of the College Seminar in the Northwest. The dates set for November will be 4th, 5th, 6th, in Seattle; 11th, 12th, 13th, in San Francisco; and 18th, 19th, 20th, in Los Angeles.

Dr. Steinberg's subjects will include examination of the patient, x-ray diagnosis, treatment of tumors, nails, causalgias, office surgery, dermatological lesions, and a new subject, the "teen-ager as a patient," presenting solutions to the problems involved with these youngsters. He will lecture three days in each location and will carry the program alone. Dr. Steinberg's past experience and recommendation makes him well qualified to do this tremendous job.

The Registrars will be Dr. Robert Barnes, Los Angeles; Dr. Robert Armstrong, Seattle; Dean Nelson, San Francisco; and Dr. Charles S. Ormond is Chairman.

STATE BOARD APPOINTMENT

Dr. Edward W. Chrencik of Hopkins, Minn., has been appointed by Governor Orville Freeman as a member of the Minnesota State Board of Chiropody Examiners and Registration for a five-year term.

DR. LALLI APPOINTED BOROUGH COUNCILMAN

Dr. Albert K. Lalli of Chester, Pa., has been appointed member of Borough Council to fill an unexpired term. He is a candidate for this office at the regular November election.

Dr. Lalli received his 25-year certificate in the National Association of Chiropodists recently.

CHIROPODIST NAMED TO INDUSTRIAL FOOT HEALTH CLINIC

Dr. G. F. Holt has been named staff chiropodist of the Industrial Foot Health Clinic at The Champion & Fibre Company, Canton, North Carolina. The foot health clinic will be an integral part of the industrial medical division of this industry.

Dr. Holt is consultant in industrial foot health for Occupational Health Services. He is also staff chiropodist for the following industrial foot programs: Pisgah Forest Division—Olin Industries; Williams-Brownell, Inc.; International Resistance Company; Oerlikon Tool & Arms Corporation.

CONVENTION DATES

1955

REGION EIGHT
Winston-Salem, No. Car.,
Sept. 30-Oct. 2, 1955
Hotel Robert E. Lee

MISSOURI ASSOCIATION OF CHIROPODISTS
St. Louis, Mo.,
Oct. 7-9, 1955
Sheraton Hotel

REGION ONE
Swampscott, Mass.,
Oct. 15-17, 1955
New Ocean House

1956

NATIONAL ASSOCIATION OF CHIROPODISTS
Chicago, Ill.,
August 1-9, 1956
Drake Hotel

PODIATRY SOCIETY OF THE STATE OF NEW YORK
New York City, N. Y.,
March 2-4, 1956
Barbizon Plaza Hotel

REGION THREE
Atlantic City, N. J.,
April 12-15, 1956
The Ambassador

DEATHS REPORTED

Dr. William J. Trusty
Asbury Park, N. J.

INVITE NON-MEMBERS TO JOIN THE N.A.C.

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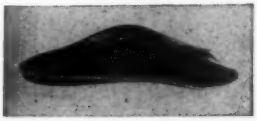

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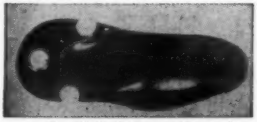

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November 18, 19, 20, 1955—Los Angeles, Calif.

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DR. DURKIN APPOINTED DEAN OF CHICAGO COLLEGE

THE BOARD OF DIRECTORS of Chicago College of Chiropody announces the appointment of Dr. Edward P. Durkin as President and Dean of the Chicago College of Chiropody. Dr. Durkin held the office of Vice President for many years.

Dr. Max Pyster, faculty member and director for more than ten years, was elected to succeed Dr. Durkin as Vice President.

CLASSIFIED ADVERTISEMENTS

Advertisements not exceeding 30 words cost $3.00. Additional words 10 cents each.

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FOR SALE: Chiropody office in professional building in large Minnesota city. All modern. Power operated Ritter chair; Sinustat. Leaving state. Write 204, c/o National Association of Chiropodists, 3301 16th St., N. W., Washington 10, D. C.

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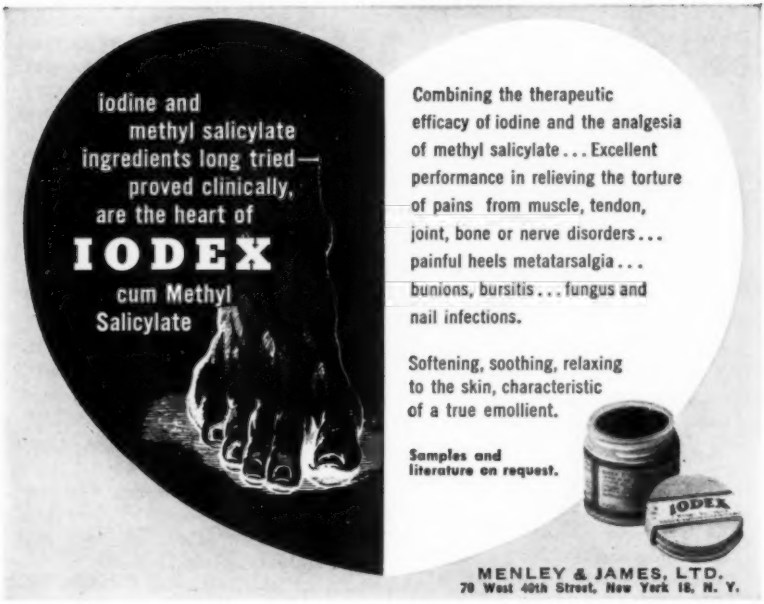
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